Revised Performance Monitoring and Evaluation Plan

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SUAAHARA

Building Strong & Smart Families

Save the Children   Jhpiego   BLOOMBERG   Center for Communication Programs

1. Introduction

Suaahara is a five year project aimed to improve the nutritional status of women and children in 20 districts of Nepal. The project focuses on improving health and nutrition behaviors at the household level through promotion of *Essential Nutrition Actions* (ENA), particularly *Infant and Young Child Feeding* (IYCF), and addressing other determinants of under-nutrition, such as availability of and access to food, hygiene, quality of health care, child spacing and socio-cultural factors including gender and marginalization. The *Suaahara* partnership provides local, national and global expertise and experience necessary to reducing malnutrition in Nepal. It includes Save the Children (SC), Helen Keller International (HKI), Jhpiego, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP), Nepal Water for Health (NEWAH), Nutrition Promotion and Consultancy Services (NPCS) and Nepali Technical Assistance Group (NTAG).

Suaahara will support the Government of Nepal (GoN) to institute nutrition interventions and policies as well as assisting building the capacity of health workers and staff from the Department of Agriculture, Local Governance, Education and Water.

The purpose of this Performance Monitoring & Evaluation Plan is to serve as a guide for the project team to collect, manage, use and report high quality performance data throughout the life of the project which will be used to monitor and evaluate the project.
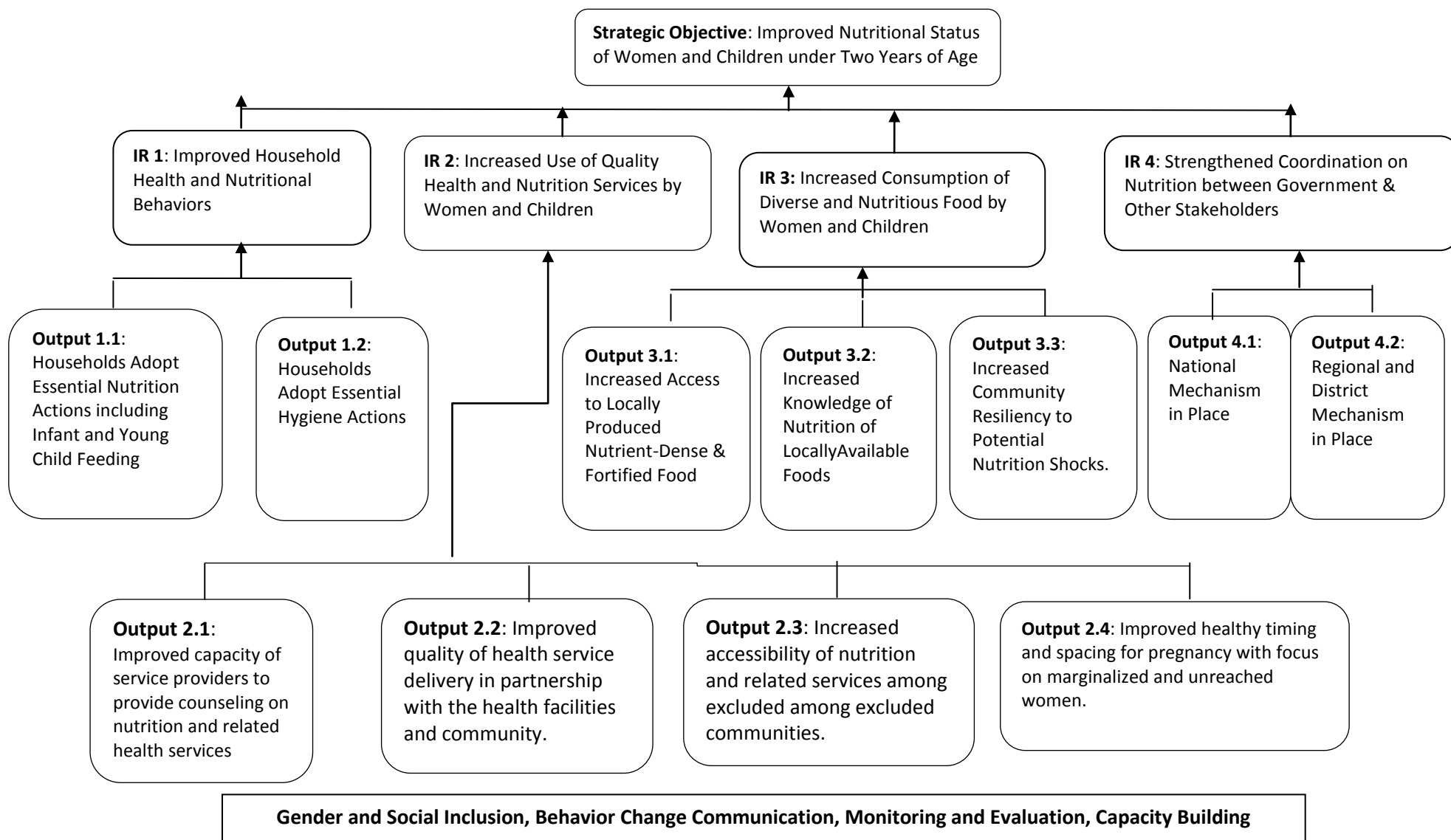
2. *Suaahara* Results Framework

The results framework for *Suaahara* is presented on page 3 of this document. This exhibits different levels of results the project wants to achieve, and the cause and effect relationship between these results. This will be used to plan, communicate, manage, monitor and evaluate the project results and development hypotheses.

The **Goal** of the project is to improve and sustain the health and well being of Nepalese and supports in particular the meeting of Millennium Development Goals 1c (Poverty-Nutrition), 4 (Child Health) and 5 (Maternal Health)

To support meeting this Goal, the project has one **Strategic Objective (SO)** which is *Improved Nutritional Status of Women and Children Under Two Years of Age*. This is the highest level of result which the project can materially affect and where the project wants to be held accountable.

Results Framework

Strategic Objective: Improved Nutritional Status of Women and Children under Two Years of Age

IR 1: Improved Household Health and Nutritional Behaviors

IR 2: Increased Use of Quality Health and Nutrition Services by Women and Children

IR 3: Increased Consumption of Diverse and Nutritious Food by Women and Children

IR 4: Strengthened Coordination on Nutrition between Government & Other Stakeholders

Output 1.1: Households Adopt Essential Nutrition Actions including Infant and Young Child Feeding

Output 1.2: Households Adopt Essential Hygiene Actions

Output 3.1: Increased Access to Locally Produced Nutrient-Dense & Fortified Food

Output 3.2: Increased Knowledge of Nutrition of LocallyAvailable Foods

Output 3.3: Increased Community Resiliency to Potential Nutrition Shocks.

Output 4.1: National Mechanism in Place

Output 4.2: Regional and District Mechanism in Place

Output 2.1: Improved capacity of service providers to provide counseling on nutrition and related health services

Output 2.2: Improved quality of health service delivery in partnership with the health facilities and community.

Output 2.3: Increased accessibility of nutrition and related services among excluded among excluded communities.

Output 2.4: Improved healthy timing and spacing for pregnancy with focus on marginalized and unreached women.

Gender and Social Inclusion, Behavior Change Communication, Monitoring and Evaluation, Capacity Building

The project's work will focus on four **Intermediate Results (IRs)** to achieve the SO. These are:
IR 1: Improved household health and nutrition behaviors
IR 2: Increased use of quality nutrition and health services by women and children
IR 3: Increased consumption of diverse and nutritious food by women and children
IR 4: Strengthened co-ordination on nutrition between government and other stakeholders

Each IR is supported by a set of 2 to 5 **Outputs**. For example, IR 1 has two outputs, which are: households adopt essential nutrition actions (ENA) including infant and young child feeding (IYCF) and households adopt essential hygiene action (EHA). These outputs support the achievement of IRs and form the basis to measure the changes made in each IR.

Indicators for SO and IRs/outputs and related definitions and (means of verification) MoVs are detailed in the *Summary Performance Data Table* beginning on page 14.

Providing a foundation to all of the activities are the cross cutting strategies of Behavior Change Communication (BCC), Training and Capacity Building, Monitoring and Evaluation, Gender and Social Inclusion (GeSI), and Public and Private Partnership.

Program Impact Pathways (PIPs)—an approach used by Helen Keller International in the past—will be used to learn <u>how</u> Suaahara activities affected outcomes with a specific focus on child stunting. In a 2008 WHO/UNICEF meeting on improving feeding of infants and young children 6 - 23 months of age, the term *program impact pathway* was defined as "the pathway from an intervention input through programmatic delivery, household and individual utilization to its desired impact". A hypothesized pathway has been developed that postulates plausible connections between *Suaahara* activities and outcomes. PIPs do not replace the Results Framework but are an additional tool to help project staff think through the links between inputs and impact and challenges in the delivery of program services.

3. *Suaahara* Indicators

Project Indicators
A detailed list of indicators for each level of result with accompanying definitions and means of verification is presented in the *Summary Performance Data Table*. These indicators are meant to track the project implementation and progress made on results, capture outcomes and impacts of the project, capture and document learning, serve as a basis for feedback to the project, and complement USAID reporting requirements.
The project will track three main types of indicators: Impact, Outcome and Output. *Impact* indicators measure the long term effect or changes (positive or negative) produced by the *Suaahara* interventions. These indicators will be used to evaluate the effectiveness of *Suaahara*. *Outcome* indicators measure the short term or medium term effects or results of one or more intervention's outputs. *Output* indicators measure the immediate products, goods or deliverables of the project.
In addition, the project will also track and report on the *USAID Operational Program(OP)indicators*. These are as follows:
- # of children under 5 who received Vitamin A from USG-supported program

- # of people trained in maternal/newborn health through USG-supported programs (disaggregated by gender and caste/ethnicity)
- # of people trained in child health and nutrition (disaggregated by gender and caste/ethnicity)
- # of people trained in FP/RH through USG supported programs (disaggregated by gender and caste/ethnicity)
- # of outlets providing socially marketed MNCH products in rural outlets
- Couple Years of Protection (CYP)

In addition to these, the project will also consider using:
- Qualitative indicators, which would help us in understanding the process behind any observed result and assess people's perception towards the results, quality of programs, implementation approach, etc. This information would help us in improving the program quality and strategies.
- Gender and social inclusion indicators: While most of the indicators presented in the matrix (attached) are disaggregated by gender and caste/ethnicity, we will also use other indicators that reflect the broad picture of gender roles in our project areas. Some examples of such indicators are, women-headed households, decision making at HH level, etc. For the sake of consistency, the project will follow the disaggregation for caste and ethnicity which HMIS is using.
- Sustainability: Suaahara will consider using the *Sustainability Framework* developed by CORE . This will help us in identifying and monitoring the areas that needs improvements so as to sustain our efforts, including organizational capacity and community dimensions. In addition, the project will use some indicators which provide an insight to the sustainability of certain interventions. Examples are, communities continue to identify early adopters (in health and agricultural sectors) and learn from them, extent to which women and other marginalized groups sustain the benefits of Suaahara activities, sustained food diversity (e.g., 4+ food groups for children) and other IYCF behaviors, etc.

4. Baseline and Evaluations

Evaluation Design

Baseline and end line surveys of the project will be done, by an external firm and will be managed by USAID Nepal, with necessary resources coming from *Suaahara.Suaahara* will only be involved in the development of the survey tool to ensure that the key *Suaahara* impact indicators will be assessed. *Suaahara* will consider including comparison areas similar to *Suaahara* project areas in baseline and end line surveys. This design will allow us to document changes in key impact and process indicators over several years of program implementation in Suaahara implementation areas, relative to non-Suaahara implementation comparison areas. Repeated cross sectional surveys will be administered in the same communities and at the same time of the year in Years 1 and 5. The project will also use DHS data to learn more about geographic patterns of nutrition related issues, but cannot be used as a primary evaluation dataset given that DHS data is usually

not representative at the district level. In addition, the DHS data on Suaahara indicators from 2011 and hopefully from 2016 will be used as a comparison with Suaahara evaluation findings. If the tabulation of selected DHS data from Suaahara districts is available, then comparisons between changes from 2011 to 2016 for INP-related indicators in clusters of Suaahara districts, compared to changes over the same period in nearby clusters of non-Suaahara districts, could provide insights into Suaahara impact. If tabulation of DHS data for clusters of Suaahara districts is not available, then trends in Suaahara districts can still be compared to national trends. Furthermore, since a Service Provision Assessment is included in the 2011 DHS, information on several new topics, such as quality, access, and utilization of health services, and capacity of health workers to deliver MCH services, will be helpful for planning program activities.

Although *Suaahara* will have semiannual process and results monitoring to analyze strategies, assumptions and results, we recommend that a mid-term performance review be done at the end of year two to provide outside perspective on results and processes to contribute guidance on the future direction of the project.

End line Qualitative Research: While the independent quantitative evaluation will assess changes at end-of-project by comparing baseline and end line values, qualitative research will focus on understanding the underlying mechanisms of change. Thus, this qualitative component of *Suaahara* evaluations will seek to answer the following types of questions: How did change occur and what are the primary characteristics of interventions that elicited the greatest amount of change? This activity will generate important knowledge that will be shared with internal partners and external stakeholders in order to build a knowledge base for future interventions.

Baseline and end line surveys

These surveys will be used to gather data using a detailed HH questionnaire that captures information on key *Suaahara* impact indicators, including anthropometry, IYCF practices, and hemoglobin among children 0-23 months of age, and maternal anthropometry and hemoglobin concentrations. Key health and nutrition behaviors (consumption of diverse foods, breastfeeding, hygiene practices) and their determinants at both the individual-level (knowledge, risk perception, efficacy beliefs, norms, and attitudes) and at the structural level (access to services, access to markets) will also be assessed. In addition, information will also be collected on other factors that influence the uptake, adoption and impact of *Suaahara* interventions, such as HH food security and dietary diversity, socioeconomic status, local food production, HH parental characteristics, maternal ENA+ knowledge, exposure to *Suaahara* and other health and nutrition interventions, exposure to media, and HH gender relationships. We will also gather data at baseline and endline on community characteristics (agriculture, health service provision, markets, etc.) and on service providers who will be involved in *Suaahara* interventions. Gathering this type of multi-level data will allow us to document the role of individual, HH, service provider and community factors as contributors to undernutrition. It will also allow stronger attribution of impacts to the *Suaahara* interventions at endline. To the extent possible, *Suaahara* will explore the innovative use of a "longitudinal" sampling frame whereby one half of the randomly selected respondents from the first survey will be tracked and interviewed once again for the end line survey. The other half of

respondents for the end line evaluation will be chosen at random and in alignment with the survey methodology decided during the evaluation design stage of Suaahara.

These surveys will be led by an independent research organization to which we will provide feedback on the design methodologies and tools to ensure that the tools developed measure *Suaahara* impact.

Targets

Realistic and more meaningful targets will be established once baseline data are in place. Targets for impact indicators will be set at the project level. This means these targets will reflect the overall project area, not the VDCs or districts. While the targets for the outcome indicators will be established at the district/cluster level and tracked through LQAS, sentinel data or other secondary sources. Targets for output indicators, as these are directly related to activities, will be set at VDC level and monitored accordingly.

5. Formative research

Qualitative research will be undertaken during the first year in order to better understand the underlying beliefs, motivations, barriers, and cultural practices pertaining to key behaviors of interest to the project. Findings from the formative research will be used to inform the overall intervention design and the behavior change strategy, focusing particularly on changing household health and nutritional behaviors (IR 1) and increased consumption of diverse and nutritious food (IR 3). This research will also assess household perceptions about both access to and quality of services in the communities (IR 2) and coordination among various stakeholders (IR 4). Formative research will use a variety of methods including the following four: (1) perceptual mapping, which is a technique used to elicit a mental picture held in common by members of a group, which represents their basic orientation towards something, such as a person, product, innovation, institution, etc., (2) The "Yes, but" technique, which is a simple method used to elicit and subsequently thematize barriers to change, (3) participant observation techniques that record "a day in the life of" an infant, and (4) participant observation with a coding scheme to assess responsive feeding. Suaahara will also use other qualitative methods in carrying out formative research.

Targeted Evaluations: Throughout the project, *Suaahara* staff will incorporate formative and summative evaluations into all intervention components used in the overall project. The complexity of the formative and summative evaluations will depend on availability of resources and the nature of the intervention component: some formative evaluations may only require a pretesting of media materials, for example, while other intervention components may require a more in-depth understanding about audience members' existing beliefs and practices. Similarly, some intervention components may be designed for single outcomes (e.g., obtaining the first immunization), whereas others may be designed for longer-term outcomes (e.g., eating diverse and nutritious foods).

6. *Suaahara* Structure and Roles in Monitoring

COP/DCOP: Provide overall insight to M&E and its direction, support the use of M&E results in making management decisions to improve program performance, ensure that the M&E system is functioning.

Technical team: Identify M&E needs for respective technical areas, work with the M&E team in designing and reviewing respective M&E plans and tools, participate in meetings to review findings and analyze data, use data/findings to improve program performance.

M&E Manager: Responsible for guiding the overall M&E strategy and implementation. Ensures that the USAID requirements for M&E and reporting are met in a timely manner with high quality. Establishes project monitoring system, for identifying and tracking indicators, develops procedures and tools, identifies capacity building needs and provides technical assistance to staff and partners, and organizes data collection to ensure quality and consistency.

Data Management Coordinator: Establishes a data management system, ensures that all data are gathered and entered in the system, and are produced for further analysis. Ensures data entered are of high quality by assisting M&E manager and technical staff in carrying out periodic data verification.

M&E Coordinator (Cluster offices): Responsible for managing M&E at the field level. Works closely with the *Suaahara* team in clusters/districts and local partner NGOs to identify capacity building needs, adapt tools to the local context, and guidedata collection. Organize and support trainings and workshops related to M&E. Support cluster and district teams in preparing reports.

M&E guidelines for *Suaahara* will be developed. Their main purpose will be to orient/guide staff of different levels and responsibilities about *Suaahara* M&E approaches, guiding principles and standards, and the role of each staff member in M&E.

7. *Suaahara* Monitoring System, Process and Tools

This section details how *Suaahara* results (outcome), output and process indicators will be monitored during the life of the project. The monitoring system will follow the sequence presented in the diagram below.

Monitoring Sequence

Data collection

Depending upon the indicator, data will be collected at different frequencies. The Summary Performance Data Table presents data source, means of verification (MoV) and frequency of collection for each indicator. The project will use a mix of primary and secondary data as follows:

Primary data sources/methods

- Data for key outcome (result) indicators of the project will be collected through lot quality assurance sampling (LQAS) as part of routine monitoring. With relatively small sample sizes, LQAS gives us the project level coverage of indicators as well as helps us to identify the sub-project areas that are performing well and thosethat are not. This helps the project team to decide on the sub project areas needing more attention and efforts. Selected *Suaahara* staff, including district-based NGO / supervisory staff, and staff from the DHO, including health facility staff, will be trained and supported to conduct lot quality assurance sampling (LQAS) as part of their routine program monitoring and supervisory work during selected months. A limited number of *Suaahara* indicators will be selected for LQAS based on district-specific program foci and challenges at the time, to determine whether or not the program is meeting a specified level of coverage in a given district or population group.

- A community self monitoring tool for ongoing assessment of project progress will be developed with local partners and tested to verify that it is appropriate. Selected leaders in target communities will use this tool to ensure that project activities are implemented as planned. The purpose will be to collect data on indicators for food availability and consumption, number of growth monitoring sessions held, social mobilization, and media events held, etc. These data, along with project monitoring information, will be aggregated by local project staff approximately every six months and presented at community meetings for discussion, analysis, and feedback.

- The project will use project records to collect and monitor a number of output indicators. For example, number of people trained number of model and home gardens, number of female community health volunteers (FCHVs)in place, number of children weighed, etc.

- *Suaahara* will seek to collect data on birth weights from several sites in as many *Suaahara* districts as feasible from providers who can take birth weights of all, or nearly all newborns, in their jurisdictions. FCHVs with high coverage of births in areas implementing the community-based newborn care package may be one source of this kind of sentinel data.

- Suaahara will consider using GIS for program planning and improvement. E.g, detailed maps of districts and/or VDCs, including Health Facilities, agriculture service centers, water sources, schools, FCHVs houses, and other key markers may be created as a base upon which to layer different program datasets for analysis and for use as a visual tool.

Secondary data sources/methods

Suaahara will incorporate data from DOHS system as much as feasible, while seeking to strengthen GON monitoring. Published and unpublished data from the Health Management Information System (HMIS), Logistics Management Information System (LMIS), DHS and National Living Standard Survey (currently being analyzed) will provide information related to some

Suaahara indicators. Gaps in the existing HMIS system include limited information on key child nutrition indicators, such as IYCF, and a lack of recording and reporting tools for nutrition, such as a nutrition register at health facility level or community/FCHV level. *Suaahara* will review existing data management mechanisms (recording, reporting, and utilization) and integrate data collection of nutrition indicators in existing community-based program registers such as IMCI, child health, and FCHV registers, into the *Suaahara* monitoring system. *Suaahara* will strengthen the capacity of district level and community level health workers/FCHVs on nutrition program monitoring to improve the service quality of community level health facilities (HPs, SHPs) and ORCs. *Suaahara* will explore collaboration with World Food Program's (WFP) vulnerable assessment mapping (VAM) unit to collect food security and nutrition indicators, including in *Suaahara* districts that overlap with the 72 districts in which WFP collects HH level FS data every four months.

Project trackers: An approach called 'project trackers' will be introduced in each district. Project trackers will be the existing staff who will track the progress made on key process, outputs and outcomes (as relevant) of their own program interventions. With support from the M&E Coordinator, project trackers will collect, compile and analyze data of their program interventions on an ongoing basis. They will be oriented on the approaches and the project tracking tool.

Data analysis and interpretation
With support from the M&E manager and the team, the cluster and district staff will analyze data, and disaggregate findings as relevant, for example, by caste and ethnicity, gender, health facility types, etc. The district, cluster and *Suaahara* teams will meet to review and discuss findings. In these meetings, project staff will review the findings, assess progress made on indicators, compare findings with the targets, between gender and across districts, identify gaps and challenges, etc.

- District staff meets monthly to analyze and review findings on key process and output indicators. Project tracker presents his/her findings using the project tracking tool, compares achievements against targets, identifies gaps and the reasons for deviations, if any, and makes corrective actions.

- Project trackers from the district and cluster staff meet as a group every quarter, to review findings made on key process, output and outcome indicators (as relevant). Data from project trackers are fed into a 'dashboard' which visually presents the status of indicators by different color codes. This enables district/cluster leads and program coordinators to identify those interventions needing more attention.

- *Suaahara* team (Kathmandu, cluster lead and M&E, district lead) meets every six months to review the results (outcomes). This is done after results-level data are available, for example, after LQAS findings are in place. The main objective of such 'results review' is to compare planned versus actual performance and results in order to strengthen and/or improve program performance.

Use of monitoring findings/results

Findings from monitoring will be used to make management decision to improve program performance through corrective and/or additional action. These actions may relate to, but are not limited to, strategies and activities, supervisory support, reallocation of resources/supplies, capacity building, etc.

8. Data Quality Control Plan

To ensure that the data collected are in compliance with USAID Data Quality Standards[1] and that data are of highest quality, a data quality control plan for each indicator is identified in the M&E indicator matrix. Different *Suaahara* partners have different mechanisms for data quality control. These will be shared among each other and used in different settings and contexts. However, the following paragraphs give a general overview of the data quality control plan for *Suaahara*.

- The way data collection and recording tools are designed affects the quality of data collected. Thus, the tools we use will be standard (as relevant), consistent, tested, and with relevant disaggregation, for example, by sex and caste/ethnicity, etc.

- Indicators will be calculated as specified in the M&E matrix.

- After data are collected, the M&E Coordinator and program staff in the district will examine this information to identify any inconsistencies or errors before data are entered into the database. The M&E Coordinator and program staff will verify data, should there be any errors or inconsistencies.

- After findings become available, the district and cluster team along with M&E staff review to see if there are any inconsistencies in trends, across groups, geographic areas, etc. Should there be differences, the team verifies (or cross verifies) before data are further analyzed and used.

- Data will be collected with the frequency specified in the M&E matrix so that these are available in time to make management decisions.

- *Suaahara* will conduct an internal Data Quality Assessment each year using the using the USAID *Data Quality Standards*. The assessment will be done for key performance indicators and the USAID OP indicators.

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[1] These are; Validity, Integrity, Precision, Reliability, and Timeliness.

9. Reporting

Suaahara will follow the Government of Nepal reporting period, i.e. July to July. The project will report to USAID as follows:

Semi-annual progress reports. These reports will be submitted within 30 days of the completion of the reporting period. These reports will contain actual accomplishments against the target set for the period, reasons for deviation (if any), information on management issues, anticipated future problems, delays or conditions that may affect implementation, information on security issues, and information on the status of finance and expenditures, etc.

Annual performance reports. These reports will contain a comparison of actual accomplishments against the goals set for the period specified in annual work plans, activity level monitoring plan and M&E plan, reasons for deviations (if any), quantitative monitoring data including information on progress toward meeting the targets, and issues related to data quality, status of finance and expenditure, information on management issues, lessons learnt and success stories, major challenges and constraints faced during the reporting period, overview of the next year's programs and other pertinent information. These reports will be submitted within 45 days of the end of the reporting period.

Performance Plan Report: The project will submit to USAID a performance plan report by December of each year.

Final report: The *Suaahara* project will submit a final report within 90 days following the award completion date.

10. M&E capacity building

The M&E team, along with the technical team, will work to strengthen the M&E capacity of partners. Initially an M&E capacity assessment of partners will be carried out. The capacity building plans will be tailored to meet partners' needs. Besides trainings and workshops, the *Suaahara* team will work with the partners in collecting monitoring data, designing and using tools, and reporting. In addition, *Suaahara* will also work toward strengthening the M&E capacity of district and VDC level health institutions and facilities through invitations to trainings/workshops and working with them.

Summary Performance Data Table

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
Strategic Objective: Improved nutritional status of women and children under two years of age.								
Height for age (Stunting)	Defined as children < 2 yrs. with height for age less than –2 Z, per new WHO standards. A Z score <-2 Z means the child is at least moderately stunted and is the standard way of calculating HAZ. The percent who are moderately stunted alone (<-2 Z but >-3 Z) can be calculated by subtracting severe stunting (see indicator below) from this indicator. Calculation: # of children < 2 yrs with height for age less than -2 Z score of WHO standards X 100 / total number of children < 2 yrs assessed	Gender and caste/ethnicity, Wealth quintile Geography: hill, mountain and terai	Suaahara comparison 44.9% intervention: 38.4% Mtn: 53.6 % Hill : 37.7 % Terai: 37.4 % Target: 32.4%	HH survey	Anthropometric assessments of sampled children	Baseline, end line	Baseline, end line report	Use of instruments, positioning the child for height measurement, calculating the age of the child, calculation of Z scores might be some issues affecting data quality. Measures include, use of standard instruments and tools, training, on site check, and repeated measurement of sub samples.
Height for age (Severe stunting)	Defined as children below 2 yrs. of age with height for age less than -3 Z score per new WHO standards. Less than -3 Z score means the child is severely or very severely stunted Calculation: # of children < 2 yrs with height for age less than -3 Z score of	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	Suaahara comparison: 16.7 % intervention: 12.5 % Target: 10.0 %	HH survey	Anthropometric assessments of sampled children	Baseline, end line	Baseline, end line report	Use of instruments, positioning the child for height measurement,, calculating the age of the child calculation of Z scores might be

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[2] Realistic targets for the project period (and interim, as relevant) will be set within 2 weeks after the baseline data are available.

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	WHO standards X 100 / total number of children < 2 yrs assessed							some issues affecting data quality. Measures include, use of standard instruments and tools, training, on site check, and repeated measures of sub samples.
Weight for age (Under weight)	A composite measure of stunting and wasting. Defined as children < 2 yrs. with weight for age less than –2 Z score, per new WHO standards. A Z score < -2 Z means the child is at least moderately underweight and is the standard way of calculating WAZ. The percent who are moderately underweight alone (<-2 Z but >-3 Z) can be calculated by subtracting severe underweight (see indicator below) from this indicator. Calculation: # of children below 2 yrs. of age whose weight for age is less than -2 Z score of WHO standard X 100 / total number of children < 2 yrs assessed	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	Suaahara comparison: 38.2% intervention: 31.7% Mtn: 41.5% Hill: 29.9% Terai: 38.4% Target: 27.7%.	HH survey	Anthropometric assessments of sampled children	Baseline, end line	Baseline, end line report	
Weight for age (Severe underweight)	Defined as children below 2 yrs. of age with weight for age less	Gender and caste/ethnicity	Suaahara comparison:	HH survey	Anthropometric assessments of	Baseline, end line	Baseline, end line	

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	than -3 Z score per new WHO standards. Less than -3 Z score means the child is severely or very severely underweight Calculation: # of children < 2 yrs with weight for age less than -3 Z score of WHO standards X 100 / total number of children < 2 yrs assessed	Wealth quintile Geography: hill, mountain and terai	9.8% intervention: 8.1% Target: 5.0%		sampled children		report	
Weight for height (wasting)	Defined as children < 2 yrs. with weight for height less than –2 Z score, per new WHO standards. A Z score between -2 and -3 means the child is moderately wasted Calculation: # of children < 2 yrs with weight for height less than -2 Z score of WHO standards X 100 / total number of children < 2 yrs assessed	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	Suaahara comparison: 13.0% intervention: 13.7% Mtn:11.2% Hill:11.6% Terai:19.1% Target: 10%	HH survey	Anthropometric assessments of sampled children	Baseline, end line	Baseline, end line report	
Weight for height (Severe acute under nutrition)	Defined as children below 2 yrs. of age with weight for height less than -3 Z score per new WHO standards. Less than -3 Z score means the child is severely or very severely wasted Calculation: # of children < 2 yrs with weight for height less than -3 Z score of WHO standards X 100 / total number of children < 2 yrs assessed	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	Suaahara comparison: 2.1% intervention : 2.6% Given the low percent, Suaahara will not be able to reduce this further.	HH survey	Anthropometric assessments of sampled children	Baseline, end line	Baseline, end line report	

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
Low Birth Weight	# of newborns whose birth weight is below 2.5 kg. X 100/ total number of births	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	Per the DHS, LBW is 12.4%. Target: 9.0%	Birth records, FCHV records	Review birth record of the child, interview mother	Baseline, end line		Technique of weighing the child, reliability of weighing instruments and recording birth weights in home setting might affect the validity. Training the periphery level health workers and volunteers, and use of standards weighing machine.
Very Low Birth Weight	# of newborns whose birth weight is below 2 kg. X 100 / total number of births	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	VLBW is not reported in the DHS. Given that this will be well below 9.0%, Suaahara will not be able to reduce this further.	Birth records, FCHV records Mothers	Review birth record of the child, interview mother	Baseline, end line		
% of children under 2 yrs. classified as having anemia	Anemia in children is defined as those with Hemoglobin level < 11g/dl. Calculation: # of children with Hb < 11 g/dl X 100 / total number of < 2 yrs children screened. Adjust the standard anemia cut off point to altitude.	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	Suaahara comparison: 53.0% intervention: 50.3% Target: 40.0%	HH survey	Screening for Hb among sampled children	Baseline, end line	Baseline, end line report	Likely to have measurement errors. Use standard technique like HemoCue consistently.
% of women with birth in last 3 yrs. with low Body Mass Index (BMI)	This is the measure of chronic energy deficiency among women. It is an approach to assessing appropriate weight for given height. The standard cut off for non pregnant and non lactating women is 18.5. Calculation: # of women 15-49 with BMI	Gender and caste/ethnicity Wealth quintile Geography: hill, mountain and terai	Suaahara comparison: 24.4% intervention:23.0% Target: 17.0%	HH survey	Testing for BMI	Baseline, end line	Baseline, end line report	Through HH survey

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	below 18.5 X 100 / total number of non pregnant women assessed.							
% of women with birth in last 3 yrs. classified as having anemia	Anemia is defined as : For non pregnant : <12 g/dl For pregnant women: <11 g/dl Calculation: # of women with Hb < 12 g/dl for non pregnant and <11 g/dl for pregnant X 100 / total number of women with birth in the last 3 years screened. Adjust the standard anemia cut off point to altitude	Caste/ethnicity Geography: hill, mountain and terai.	Suaahara comparison: 45.1% intervention: 43.0% Target: 35.0%	HH survey	Screening for Hb among women sampled.	Baseline, end line		Likely to have measurement errors. Use standard technique like HemoCue consistently.
Intermediate Result 1: Improved household health and nutritional behavior								
Output 1.1: Households adopt Essential Nutrition Actions (ENA) including Infant and Young Child Feeding (IYCF).								
% of pregnant and lactating women who use tobacco products one or more times in the previous 24 hours	# of pregnant and lactating women who use tobacco products / total # of pregnant and lactating women X 100	Rural, urban	Suaahara comparison: Smoking: 10.0% Other tobacco: 7.5% intervention: Smoking: 6.6% Other tobacco: 5.6% pregnant and lactating women, comparison : 14.6%	Suaahara HH survey report	Review reports and compile data	Baseline, endline	Baseline report and end of project report	Recall bias. Train enumerators in using the standard questionnaires.

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
			intervention: 9.3% Target: < 6 %					
# of children 6-59 months who received Vitamin A from USG supported program (Mandatory).	Count the number of children 6-59 months old who have received Vitamin A in the last 6 months from the time data is collected.	Rural, Urban	2013:416,957 2014:427,358 2015:437,887 2016:453,314	HMIS data	Review data	Annual	Annual report	This is a government program. Suaahara will support the government in its efforts but is not directly responsible for vitamin a distribution. Chances of double counting. In order to eliminate this, report the number done in the last 6 months only.
% of infants 0-5 months who were put to the breast within 1 hour of birth	This indicator is the measure of early initiation of breast feeding after birth. Calculation: # of children 0-5 months who were put to the breast within one hour of birth X 100 / total number of 0-5 months children in the sample.		Suaahara comparison: 40.4% intervention: 37.6% Target: 50.0%. Baseline is for children 0-23.9 months of age	Suaahara HH survey report	Interviews with mothers of infant 0-5 months	Baseline, end line	Baseline report and end of the project report	Recall bias. Train enumerators in using the standard questionnaires.
% of infants 0-5 months who received only breast milk during the previous day.	This indicator measures exclusive breast feeding, which is defined as the children below 6 months of age consume only breast milk and no other liquids	Gender Age (0-1, 2-3, 4-5 and 0-2, 3-5 months)	Suaahara comparison: 52.5% intervention: 46.0%	Suaahara HH Survey report	Interviews with mothers of infant 0-5 months	Baseline, end line LQAS	Baseline report and end of the project report	May be slightly overestimated because some infants who were given other liquids

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	or solid foods with exception of drops or syrup of consuming of medicine. Calculation: # of children 0-5 months who received only breast milk during the previous day X 100 / total number of 0-5 months children sampled.		Target: 61.0%				Annual report	irregularly may not have received them in the day before the survey.
% of children 6-23 months of age receiving foods from ≥4 food groups during the previous day	The 7 food groups are: grains, roots and tubers; legumes and nuts; dairy products; flesh foods; eggs; vit A rich fruits and vegetables; and other fruits and vegetables. Children receiving foods from at least 4 of these groups qualify for this indicator. Calculation: # of children 6-23 months of age receiving foods from ≥4 food groups during the previous day X 100 / Total number of 6-23 months children sampled	Gender Age (6-8, 9-11, 12-23 months)	Suaahara comparison: 44.1%intervention: 47.1% Target : 60%	Suaahara HH survey report LQAS report	Interviews with mothers of children 6-23 months	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Chances of recall bias. Check for reliability by repeated survey of sub samples.
Minimum meal frequency among children 6-23 months	This indicator measures the proportion of children 6-23 months of age who received solid, semi solid and soft food the minimum number[3] of times or more. This is calculated as: **Breastfed children** 6-23 months who received solid, semi solid or	Gender	Suaahara comparison: 74.8% intervention: 69.7% Target: 75.0%	Suaahara HH survey report LQAS report	Interviews with mothers of children 6-23 months	Baseline, end line LQAS	Baseline report and end of the project report Annual report	

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[3] Minimum is defined as: 2 times for breastfed infants 6-8 months; 3 times for breastfed children 9-23 months; and, 4 times for non-breastfed children 6-23 months.

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	soft foods the minimum number of times or more during the previous day x 100 / Breastfed children 6-23 months of age.

Non-breastfed children 6-23 months who received solid, semi-solid or soft foods or mild feeds the minimum number of times or more during the previous day x 100 / Non-breastfed children 6-23 months of age | | | | | | | |
| Prevalence of children 6-23 months receiving minimum acceptable diet | This indicator measures the proportion of children 6-23 months of age who received a minimum acceptable diet (apart from breast milk). This is a composite indicator of dietary diversity and meal frequency and is calculated as:

Breast fed children 6-23 months who received solid, semi solid or soft food the minimum number of times or more during the previous day [4] x 100 **/** Breast fed children 6-23 months of age

Non-breast fed children 6-23 months who received solid, semi | Gender

Age: 6-11 months, 12-17 months, and 18-23 months. | Suaahara comparison: 36.2% intervention: 36.1%

Target: 25.0% | Suaahara HH survey report

LQAS report | Interviews with mothers of children 6-23 months | Baseline, end line

LQAS | Baseline report and end of the project report

Annual report | |

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[4]Minimum is defined as: 2 times for breastfed infants 6-8 months; 3 times for breastfed children 9-23 months

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	solid or soft foods or milk feeds the minimum number of times or more [5] during the previous day x 100 / Non-breast fed children 6-23 months of age. Dietary Diversity Minimum dietary diversity for children 6-23 months is defined as 4 or more food groups out of the following 7 groups: legumes and nuts; dairy products; flesh foods; eggs; vit A rich fruits and vegetables; and other fruits and vegetables.							
% of children 6-23 months of age who consumed vitamin A rich animal-source foods during previous 24 hours.	Vit A rich animal source food are eggs, organ meat, other meat (chicken), fish, cheese and milk Calculation: # of children 6-23 months of age who consumed vitamin A rich animal-source foods during previous 24 hours X 100 / children 6-23 months of age assessed.	Gender, age (6-11, 12-23 months)	Suaahara comparison: 52.8% intervention: 62.9% Target: 75.0%	Suaahara HH survey report, LQAS report	Interviews with mothers or care takers of children 6-23 months	Baseline, end line	Baseline report and end of the project report	Chances of recall bias. Check for reliability by repeated survey of sub samples.
% of children 6-23 months of age who consumed iron-rich animal-source foods during previous 24	Iron rich animal foods are organ meat, fish and egg Calculation: # of children 6-23 months of age who consumed Iron rich animal-	Gender and age (6-11, 12-23 months)	Suaahara comparison: 15.2% intervention: 14.7%	Suaahara HH survey report, LQAS	Interviews with mothers or care takers of children 6-23 months	Baseline, end line LQAS	Baseline report and end of the project report	

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[5] Minimum is defined as 4 times for non-breastfed children 6-23 months.

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
hours.	source foods during previous 24 hours X 100 / children 6-23 months of age assessed.		Target: 35.0%	report			Annual report	
% of sick children 6-23 months of age fed more after their illness	This indicator measures if the child was fed more after an episode of diarrhea. "More' is measured against the minimum number of times the child should be fed. These are; a) two times for breastfed infants 6-8 months; b) three times for breastfed children 9-23 months; c) four times for non-breastfed children 6-23 months. Calculation: # of sick children 6-23 months of age fed more than usual X 100 / # of children 6-23 months who were sick in the last 2 weeks	Gender	Suaahara comparison: 14.6% (during diarrhea) intervention: 7.5% (during diarrhea) Target: 30.0%	Suaahara HH survey report. LQAS report	Interviews with mothers or care takers of children 6-23 months	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Chances of recall bias. Check reliability by repeated survey of sub samples.
Mean dietary diversity of women of reproductive age.	The 8 food groups are Starchy staples (grain, root and tubers), legumes and nuts, dairy, meat (organ and other meat), eggs, dark leafy green vegetables, vitamin A rich fruits and vegetables, other fruits and vegetables, Calculation: Sum of the number of food groups (0-8 above) eaten by the women in the last 24 hours /total number women with children 6-23 months interviewed	Wealth quintile Rural, urban	Suaahara comparison: 3.7 food groups intervention: 3.9 food groups Target: ≥4 food groups	Suaahara HH survey report LQAS report	Interviews with mothers of children 6-23 months	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Chances of recall bias. Check reliability by repeated survey of sub samples.
% of women who	# of women who received iron		Suaahara	Suaahara	Interviews with	Baseline,	Baseline	Chances of recall

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
received full course of iron during their pregnancy	tablets for at least180 days during her last pregnancy X 100 / total number of women interviewed		comparison: 39.0% intervention: 37.0% Target: 45.0%	HH survey report, HMIS report	mothers of children 6-23 months	end line	report and end of the project report	bias. Ask to produce ANC or other relevant cards, if any.
Number of children under five years reached by USG supported nutrition programs	This indicator estimates the number of under five years old children who are reached by USG supported nutrition programs in a given year. USG supported nutrition program includes, BCC activities, home or community gardens, poultry distribution, micronutrient supplementation, GMP and management of malnutrition. Count each child once, even if the child is reached by multiple nutrition interventions.	Gender	2013:159,729 2014:169,712 2015:179,695 2016:189,678	Project records.	Review project records of intervention.	Annually	Annual report	Chances of double counting of same child if he or she is reached by multiple interventions. Use Total Reach methodology adopted by SC to eliminate such double counting.
Output 1.2: Households adopt Essential Hygiene Actions (EHA)								
% of children under five years who had diarrhea in the prior two weeks.	Diarrhea is defined as the passage of 3 or more loose or liquid stools per day. This indicator is calculated as : # of children under 5 years of age experiencing episode of diarrhea at anytime during the two weeks preceding data collection / # of children under 5 years of age surveyed.		Suaahara comparison: 12.5 % Suaahara intervention: 12.5 % Suaahara target : 10 %	Suaahara HH survey report LQAS report	Interview with the mothers	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Definition of diarrhea among different groups may not be consistent. Prevalence varies seasonally. Track throughout multiple years.
% of mothers who dispose of their youngest child's fecal	Safely is defined as: dropping into a toilet facility, and rinsed/washed away (water	Rural, urban	Suaahara comparison: 29.4%	Suaahara HH survey report	Interview with the mothers	Baseline, end line	Baseline report and end of the	None or little

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
matter safely	discarded into a toilet facility – except composting toilet, water discarded into sink or tub connected to a drainage system. Calculation: # of mothers who report disposing youngest child's feces safely the last time s/he passed stool X 100 / total number of mothers interviewed.		intervention: 30.6% Target: 45.6%	LQAS report		LQAS	project report Annual report	
Percent of HHs using an improved sanitation facility	Improved sanitation facility is defined as those that include a flush or pour/flush facility connected to piped sewerage system; a septic or a pit latrine; pit latrine with a slab; composting toilets; or ventilated improved pit latrines.(Numerator). Denominator: All HHs selected randomly. In the survey this is assessed by asking question "what type of toilet facility do member of your HH usually use?"	Rural, Urban Wealth Quintile	(Toilet only). Once the final report is ready, Suaahara will add the other improved sanitation facilities mentioned to the left. Suaahara comparison: 72.8% intervention: 67.8% Target: 77.8%	Suaahara HH survey report	Household survey	Baseline, end line LQAS	Baseline report and end of the project report Annual report	This is self reported which may not truly reflect the actual behavior. This may require observing the facility to determine the signs of usage. Not all household members may regularly use the facility, particularly children, who are left to defecate in open field.
Percent of population in target areas practicing open defecation	This indicator measures the proportion of population who do not use a toilet facility. This is calculated as: Number of people who report practicing open defecation x 100 / Total number of people	Rural, Urban Wealth Quintile	Suaahara comparison: 27.2% intervention: 32.2 % Target: 20.0%	Suaahara HH survey report LQAS report	Interviews with mothers of children 6-23 months	Baseline, end line LQAS	Baseline report and end of the project report Annual report	None or little

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	interviewed in the sample							
Number of communities (VDCs) certified as 'open defecation free' as a result of USG assistance.	This indicator identifies the number of VDCs which are declared ODF. The declaration is made with a team consisting of DWASH, VDC and other district level representatives in a formal setting. To calculate this indicator: Count the number of VDCs labeled as 'ODF' or certificate declaring that the VDC is ODF.	Rural, Urban	2013: 8 2014: 35 2015: 25	Suaahara monitoring reports.	Supervision and monitoring visits.	Baseline and annually	Annual report	Once VDCs are declared ODF, there are chances that such VDCs may not remain ODF. Sampled HHs in a VDC labeled as ODF may be visited to see how many of them have latrines.
% of child caregivers and food preparers with appropriate hand washing behavior	Food preparers and caregivers are the ones who prepare most of the food in the HH and provide most of the care for young children. Appropriate hand washing behavior includes washing hands with soap or ash and water at **critical times** (after defecation, after cleaning baby's bottoms, before food preparation, before eating, before feeding children). Calculation: # of food preparers and caregivers who report using soap or ash for washing hands within the past 24 hours at two or more critical times (after defecation and at least one of the remaining 4 above X 100 / total number of caregivers and food preparers interviewed.	By critical times	These percents are for maternal handwashing before feeding child. Percents for the remaining critical times will be provided once the baseline report is available. Suaahara comparison: 23.6% intervention: 30.0% Target: 45.0%	Suaahara HH survey report LQAS report	Interview with the mothers and caregivers	Baseline, end line LQAS	Baseline report and end of the project report Annual report	None or little

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
% of HHs with access to essential hand washing supplies.	'Essential handwashing supplies' includes: water (stored in separate container than in the washing device), Soap (or locally available cleansing agent), and washing device allowing for unassisted handwashing (tap, basin, bucket etc.) Calculation: # of HHs that have access to essential handwashing supplies / total # of HHs surveyed x 100	Rural, urban	Percents are for mothers who could demonstrate using clean/running water, followed by using soap/ash. Data are currently available for comparison and intervention communities combined. A target for access to supplies will be used once the baseline report is available. Suaahara, water (comparison and intervention): 77.7% Target: 85.0% Suaahara soap ash	Suaahara HH survey report LQAS report	Observation with a checklist during HH or LQAS survey or during site visits.	Baseline, end line LQAS	Baseline report and end of the project report Annual report	None or little. To minimize observer bias, a standardized observation checklist will be used.

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
			(comparison and intervention): 61.5% Target: 75.0%					
% of HHs with soap and water at hand washing station commonly used by family members	Number of HHs with soap and water at the hand washing station to wash hands x 100 / Total number of HHs in the samples observed.	Rural, Urban Wealth Quintile	Suaahara comparison: Water: 59.5%, Soap/Ash: 46.5 % intervention: Water: 70.8%, Soap/Ash: 53.8) Target: 65% (for both water and soap/ash).	Suaahara HH survey report LQAS report	Observation with a checklist during HH or LQAS survey or during site visits.	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Not all HHs may have a dedicated hand washing station.
Percent of HHs using an improved drinking water source	Improved drinking water source are the ones which are protected by outside contamination, particularly fecal matters. This includes, piped water, public tap, protected wells, tube wells, and bore hole. This is calculated as: Number of HHs in the sample with an improved drinking water source x 100 / Total number of HHs in the sample.	Rural, Urban Wealth Quintile	Suaahara comparison: 87.0 % intervention: 89.0 % Target : 90.0%	Suaahara HH survey	Interview with the HH member Observation	Baseline and end line LQAS	Baseline report and end of the project report. Annual reports	This indicator does not guarantee that the water is of good quality but only assumes. This depends on how well the specific source is protected.
Intermediate Result 2: Increased use of quality health and nutrition services by women and children								
Output 2.1 Improved capacity of service providers to provide counseling and services on nutrition and related maternal and child health services								
Number of people	'USG supported' means those	Gender and	1368 (Male	Training	Review training	During each	Annual	Chances of double

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
trained in maternal/newborn health through USG supported programs (Mandatory)	training activities conducted as part of Suaahara interventions, in the Suaahara specified districts and facilities. 'People' includes health workers, and heath staff in health facilities who are trained in MNCH-N tool in two districts etc.	caste/ethnicity.	397; Female 971) Yr 2013 803 (Male:257, Female:546) Yr 2014: 565 (Male 140 & Female 425)	records	records	training event.	report	counting the same person. Conduct training report audits.
Number of people trained in child health and nutrition (Mandatory)	'People' includes health workers, volunteers, non-health personnel, 1000 day mothers etc.	Gender and caste/ethnicity.	Total: 416,740 2013: 250272 2014: 99568 2015: 66900	Training records	Review training records	During each training event.	Annual report	Chances of double counting the same person. Conduct training report audit.
% of health workers with improved knowledge in counseling and related MCH services as a result of the trainings	This indicator assesses the increase in knowledge as a result of trainings. This is calculated as the difference in scores between pre and post tests. This will be done through instituting pre and post tests of individual participants. (Post test score – Pre test score) = % point change A standard question will be developed which will be instituted in pre and post tests.	Training types	Baseline percents forthcoming in the baseline report. Target: 80.0% of trained health workers will have improved knowledge as a result of the trainings.	Training pre and post test records	Review training records	During each training event.	Annual report	Reflects the overall quality of the training, not necessarily the knowledge gained by individual participants.
% of service providers providing adequate nutrition counseling.	This indicator assesses the proportion of service providers who provide age specific nutrition counseling during	By type of service providers.	Baseline percents forthcoming in the baseline	Clients at HFs.	Client exit interviews	Semiannual	Annual reports	Depends upon to what extent the client recalls the messages given by

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	interaction with mothers. The counseling is assessed in terms of AFATVAH (Age, Frequency, Amount, Thickness, Variety, Active feeding, and Hygiene). This is calculated as: Number of service providers following the AFATVAH during interaction with mothers x 100 / Total number of service providers assessed.		report. Target: 50.0% of trained health workers					service providers.
Output 2.2: Improved quality of health service delivery in partnership with the health facilities and community								
Percent of USG assisted service delivery points that experience a stock out of key MCH commodities at any time during the defined reporting period of specific tracer drugs that the SDP is expected to provide.	Key MCH commodities include: ORS, Cotrim, Zinc, timer, iron, folic acid and weighing scale. This indicator is calculated as: # of SDPs experiencing stock out of any key MCH commodities during the given year / Total # of SDPs in the catchment area monitored X 100		Suaahra target < 15 %	Commodities and logistics management system.	Review of LMIS reports	Annually	Annual report	Differences in LMIS and Suaahara reporting period. Adjust by the months.
Percent of clients satisfied with care received from service providers	Number of clients satisfied with are received from service providers x 100 / Number of clients using services	By type of services, type of HF	Baseline percents forthcoming in the baseline report. Target: 70.0%	Clients at HFs.	Client exit interviews	Semiannual	Annual reports	This is very subjective as clients may have different perspectives on satisfaction and quality.
Number of HFOMCs who have been engaged in a QI	Sum of HFOMCs using Partnership Defined Quality for nutrition and health .	Type of HFs	Target: 200 HFOMCs	Project records	Review project records	Annual	Annual reports.	None or little. QI process in some HFOMC may not

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
process								remain to be functional.
Number of HFOMCs who have addressed at least two issues related to quality each year.	Sum of HFOMCs who have addressed two or more quality related issues identified by the HFOMC – PDQ committee	Type of quality issues	Target: 125	HFOMC – PDQ documents. Observation reports.	Review documents. Supervision and monitoring visits.	Annual	Annual reports.	None or little. Need to ensure that the marginalized people are actively involved in identifying quality and in the quality improvement process.
Output 2.3: Improved access to nutrition and related maternal and child health services, particularly, among excluded communities								
% of pregnant women who receive at least 4 ANC visits	Number of women who had at least 4 ANC visits during last pregnancy X 100 / Total number of women with a child below 24 months interviewed. Suaahara will also report on number of visits.	Number of visits: 1,2,3,4,and more	Suaahara comparison: 52.5% intervention: 63.0% Target: 74.0%	Suaahara HH survey report LQAS report	Interview mothers with a child below 24 months of age.	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Chances of recall bias. to minimize this ANC visits during 'last pregnancy' should be considered. If possible, verify against ANC or other relevant cards records.
% of post partum women and newborns who receive at least 3 postpartum/postnatal visits.	Number of women who had postnatal visits at 1, 3 and 7 days of delivery X 100 / Total number of women with a child below 24 months interviewed. Suaahara will also report on number of visits.	Days: 1, 3 and 7	Suaahara comparison: 12.6% intervention: 16.7% Target: 30.0%	Suaahara HH survey report LQAS report	Interview mothers with a child below 23 months of age.	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Verify against any records that are available.
% of children with diarrhea in the last 2 weeks treated with ORS and Zinc	Number of children treated with ORS and zinc X 100 / total number of sampled children below 24 months reported with diarrhea in the last 2 weeks.	None	Per the DHS, 45.0% of children with diarrhea were given ORS.	Suaahara HH survey report LQAS	Interview mothers with a child below 23 months of age.	Baseline, end line LQAS	Baseline report and end of the project report	Chances of recall bias. To minimize recall bias a two weeks reference period should be

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
			Target: ORS: 60.0%. 6% were given zinc. Target: 20.0%.	report HMIS report	Review reports		Annual report	used.
Percent of newborns receiving post natal health check within 2 days of birth	This indicator is important given the crucial role of the postnatal period for newborn health and survival. This is calculated as: Number of newborns that received a postnatal care check within 2 days after delivery x 100 / Total number of live births		Suaahara comparison: 39.8% intervention: 49.1 % Target: 55.0%	Suaahara HH survey report LQAS report	Interview mothers with a child below 23 months of age.	Baseline, end line LQAS	Baseline report and end of the project report Annual report	Chances of recall bias. May have problems in understanding what constitutes post natal check ups.
Percent of children under five years old with diarrhea treated with oral rehydration therapy (ORT)	Children under five years of age who were treated with ORT[6] x 100 / Total children under five years of age in the sample who were reported of having diarrhea in the two weeks preceding and survey.	Gender	Suaahara comparison: 42.9% intervention: 34.9 % Target: 45.0%	Suaahara HH survey report HMIS	Interview with mothers with a child below five years of age.	Baseline and end line Annually	Baseline and end of the project report Annual report	Chances of recall bias. To minimize recall bias a two weeks reference period should be used.
Percent of children with pneumonia taken to appropriate care.	Children under five years of age with acute respiratory tract infections (ARI) symptoms for whom care was sought from a health facility or provider x 100 /		Baseline percents forthcoming in the baseline report	Suaahara HH survey report	Interview with mothers with a child below five years of age	Baseline and end line	Baseline and end of the project report	Chances of over reporting as traditional practitioners, pharmacies or

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[6] Receiving ORT is defined as receiving Oral Rehydration solution (ORS), Recommended Home Fluids or increased fluids.

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	Children under five years of age who were reported of having ARI, exhibiting symptoms of cough with rapid breathing, during the two weeks preceding the survey.		Target: 55.0%	HMIS		Annually	Annual report	other shops may be included as under 'health facility or provider'
Percent of births attended by SBA	Skilled Birth Attendant (SBA) is defined as deliveries conducted by doctors, staff nurses and trained ANMs. This indicator is calculated as: Number of women whose last delivery was attended by SBA x 100 / Total number of women with children under five years of age interviewed.	Wealth Quintile	Suaahara comparison: 31.7% intervention: 42.5% Target: 50.0%	Suaahara HH survey HMIS	Interview with mothers with a child below two years of age. Review HMIS data	Baseline and final Annually		Possibility of recall bias. There may also be a possibility of mothers not identifying the attendant who assisted with her delivery.
Number of health facilities with established capacity to manage acute under nutrition			Under discussion with UNICEF and CHD					
Output 2.4: Improved healthy timing and spacing for pregnancy with focus on marginalized and unreached women								
Number of additional USG assisted community health workers providing FP information and / or services during the year.	This indicator measures the additional CHWs who provide FP information and/or services, resulting in an increase in accessibility and coverage. Community Health Workers are taken as Female Community Health Volunteers. To calculate this indicator count the number of new and additional CHWs who provide		2013: 7,000 2014: 8,000 2015:8,025 2016: 9,025	FP services records of the project	Review records	Annually	Annual reports	Little or none.

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	FP information and services supported by USG.							
Percent of USG assisted service delivery sites providing FP counseling and/or services.	Service delivery sites are health posts, sub health posts, outreach clinics, and health centers. FP counseling is the one which is provided in the context of visit with a service provider. This indicator is calculated as: Number of USG assisted service delivery sites providing FP counseling and/or services x 100 / Total number of USG assisted service delivery sites.	Type of facilities	2013: 43.0% 2014: 60.0% 2015: 75.0% 2016: 85.0%	HF records LMIS	Monitoring visits Review of HF records	Annually	Annual report	None or minimal. Possibility of confusions in identifying HFs assisted/not assisted by USG.
Number of people trained in FP/RH through USG supported programs (mandatory)	'USG supported' is defined as trainings in FP/RH conducted as part of Suaahara interventions. 'People' include health workers and volunteers in the health facilities and SUAAHARA project areas. Training refers to the HTSP training which is linked to ANC and PNC services	Gender	2013: 1,567 2014: 2,102	Suaahara training records	Review training records	Every 3 months	Annual and semiannual repots	Chances of double counting the same health worker. Conduct data audit.
% of women who receive healthy timing and spacing for pregnancy (HTSP) counseling.	# of women with a child under two years of age who received HTSP counseling during pregnancy, child birth and post partum period / Total # of women with a child below two years interviewed x 100	By various stages: pregnancy, child birth and postpartum.	Percents are for recall of all 3 messages about HTSP. Suaahara comparison: 52.0 % intervention: 50.2 %	Interview with the mother	Baseline, end line LQAS	Baseline and end of the project Annually	Baseline, annual and end of the project report Annual report	Recall bias is likely. Repeat survey of a sub sample of mothers for reliability

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
			Target: 65 %					
% of USG assisted service delivery points (SDPs) that experienced a stock out at any time during the defined reporting period of any contraceptive methods that the SDP is expected to provide.	Service delivery points are: health posts, sub health posts, outreach clinincs, health centers and hospitals. This indicator is defined as the percentage of service delivery points that experienced a stock out of any contraceptive method during the past 12 months. Calculation: # of SDPs that experienced a stock out of any contraceptive method during the given year / # of monitored SDPs that are expected to provide contraceptive services.		Target for Suaahara: <15 %	Commodities and logistics management system.	Review of LMIS reports	Annually	Annual Report	Differences in LMIS and Suaahara reporting period. Adjust by the months.
Number of people that have seen or heard a specific USG-supported FP/RH message (Mandatory)	'USG supported' means those activities conducted as part of Suaahara interventions, in the Suaahara specified districts and facilities. 'People' includes women of reproductive age	Gender	Target: 300,000	Baseline and end line	Baseline and end line	Baseline and end of the project	Baseline and end of the project report.	Recall bias is likely. Repeat survey of a sub sample of mothers for reliability.
Couple Years of Protection (CYP) in USG supported programs.	CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. Calculation:	By commodities	Target: 2,716	Logistics management information system, service statistics (facility and community).	Review HMIS, logbooks, or registers and tally the total number of each contraceptive method sold or distributed in	Continuous collection of data	Annual reporting	Some data validity may be an issue owing to community based distribution (CBD) of commodities by other programs. Carryout a

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
	Method-specific CYP = (quantity of the family planning method distributed or sold to clients over a 12-month period) x the conversion factor for that method[7] The conversion factor represents the number of units needed to protect a couple against pregnancy for one year. Total CYP = Sum of the CYPs across all methods			the past 12 months.				mapping exercise of project areas to identify other programs doing CBD.
Intermediate Result 3: Increased consumption of diverse and nutritious food by women and children								
Output 3.1: Increased access to locally produced nutrient dense and fortified foods								
# and % of VMFs and community brooding centres established	Village Model Farm is a demonstration farm led by a leader farmer for vegetable garden and poultry. It is a platform to transfer the skills and knowledge related to homestead food production and ENA to mother groups who have under 2 years old children and other farmers.	District, agro-ecology	VMFs: 1,154 Community brooding centers: 20	Suaahara monitoring reports on VMF.	Review reports	Every 3 months	Semiannual and annual reports.	None or minimal
Number of beneficiaries with access to home or community garden	Sum of the total households who have home gardens. Multiply these HHs with average family size to come up with the total beneficiaries with access to home gardens.	Rural, Urban	265,500	Project records on home garden	Supervision and monitoring visits.	Semiannual	Annual reports.	Little or none.
Number of home or	Sum the total number of home		59,000	Project	Supervision and	Semiannual	Annual	Little or none.

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[7] Conversion factors/CYP: Condoms (120 units), Pills (15 cycles), Depo Provera (4 doses), Copper T, IUD (4.6/IUD), Sterilizations (13), Standard days method (1.5 CYP per trained, confirmed adopter), Norplant (3.8 per implant), LAM (4 active users / CYP).

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
community gardens established	gardens established			records on home garden	monitoring visits.		reports.	
Number of people trained in HFP/Ag	People include model farmers, members for 1000 day HHs, and farmers from food insecure districts	Gender	84,914 (Male: 14,616 &Female: 70,302 Yr. 2013: 60,350 (Male:14,285 & Female: 46,065) Yr. 2014: 24,568 (Male:331 & Female:24237)	Project training records	Review of records	During each training event.	Annual reports	Little or none
Mean # of MN rich vegetable cultivated by HH each year.	Total number of micronutrient rich vegetable (dark green leafy vegetables, yellow orange color vegetables and other micronutrient rich vegetables like broccoli) cultivated by household/total number of surveyed households	District/cluster	Per the AAMA baseline: 2.0 Target: 5.0	HH survey, LQAS survey	Interview with beneficiaries mother	Baseline and end line LQAS	Baseline and Annual reports	None or minimal
Mean # of improved chickens owned per household	Total number improved poultry rearing by household /Total number of surveyed household	District/cluster	Per the AAMA baseline: 0 Target: 3.0	HH survey LQAS survey	Interview with beneficiaries mother	Baseline and end line LQAS	Baseline and annual reports	None or minimal
Number of chicken distributed	Count the total number of chicken distributed each year.		2013: 40,000 2014: 198,000 2015: 57,000	Record of chicken distribution	Review records	Annually	Annual reports	None or minimal
Total # of eggs produced per household	Total number eggs produced in the previous week	District/cluster	Per the AAMA baseline:<1.0 Target: 3.0	HH survey LQAS survey	Interview with beneficiaries mother	Baseline and end line	Baseline and annual reports	None or minimal

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
						LQAS		

Output 3.2: Increased knowledge of nutrition and locally available foods

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
% of mothers and other caregivers able to recite correctly ENA messages on appropriate diversity	Key Dietary diversity message: Mother able to recite key ENA messages X 100 / total number of mothers with children, 2years interviewed.	Cluster, ethnicity	Baseline percents forthcoming in the baseline report. Target: 60.0%	Suaahara HH survey LQAS	Interview with mother of children 0-23 months of age	Baseline and end line LQAS	Baseline, annual and end line reports. Annual report	Quality of data is dependent on a number of factors, such as, quality of questionnaires, quality and characteristics of interviewer, technique of interviewing etc.
% of FCHVs able to recite correctly ENA messages on appropriate diversity	Key Dietary diversity message: FCHV/poshan aama able to recite key ENA messages X 100 / total number of FCHVs/poshan aamas	Cluster, ethnicity	Baseline percents forthcoming in the FCHV baseline report. Target: 80.0%	Suaahara HH survey LQAS	Interview with FCHVs.	Baseline and end line LQAS	Baseline, annual and end line reports. Annual report	Quality of data is dependent on a number of factors, such as, quality of questionnaires, quality and characteristics of interviewer, technique of interviewing etc.

Output 3.3:Increased community resiliency to potential nutrition shocks

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
% of VDCs trained in DRR with content of nutrient resiliency	# of VDCs trained in DRR with content of nutrient resiliency/ total # of VDCs with Suaahara interventions x 100	Cluster Ecological region	Target: 60 VDCs	Suaahara monitoring report	Review report	During the training event.	Annual	None or minimal
Number of VDCs developing disaster risk reduction	# of VDCs with disaster risk reduction plans who have at least 5 of the core competencies[8] for	Food insecure districts	2013:5 2014: 15 2015: 20	Suaahara monitoring report	Review report	Annually	Annual	None or minimal

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[8] Core competencies for nutrient resiliency are: Improve local storage practice, promote improvement of strategic seed banks and national seeds storage system, encourage to convert landslide areas into plantation, invest on river training especially to reduce flood related risks, promote land and water conservation practices, increase irrigation

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
preparedness plans (that include at least 5 of the core competencies for nutrient resiliency.	nutrient resiliency/ total # of VDCs with Suaahara interventions x 100		2016: 20					
# of small grants innovations made	Defined as grants up to $ 5,000 (per grant) to test and seed innovative ideas that can eventually inform program implementation.	Cluster	12	Suaahara monitoring reports	Review report	Annually	Annual	None or minimal
Intermediate result 4: Strengthened coordination on nutrition between government and other stakeholders								
Output 4.1: National mechanisms in place								
# of formal meetings held by HLNFSSC technical advisory group (addressing nutrition/IYCF)	Count the number of meetings held by NNSC technical advisory group addressing nutrition/IYCF.	None	Twice every year	Meeting reports	Review meeting reports	Every 6 months	Annual and semiannual reports.	
Geographic expansion of Suaahara interventions beyond Suaahara districts	Count the number of VCS/Districts taking up Suaahara interventions	Clusters/regions	Expansion of manuals and other materials to World Bank and Feed the Future sites. Radio messages are for the 20 Suaahara districts but we expect listeners in other districts	VDC/DDC reports, Suaahara	Review reports	Annually	Annual	

coverage where water resources are available without negative impact on ground water, encourage intergrated production syster, improve construction standards for animal shelters and hen pens, and discourage agricultural practices that lead to disaster. (Source: National Strategy for Disaster Risk and Management in Nepal, 2008).

Performance Indicator	Definition/Calculation	Data Disaggregation	Target[2]	Data Source	Data Collection Method	Frequency	Reporting Tool	Data quality issues/Verification Plan
			as well.					
Output 4.2: Regional and district mechanism in place								
District nutrition and food security committee established at district and regional levels in collaboration with National Planning Commission.	Count the number of district nutrition and food security committee.	By districts and region	2013: 20 Suaahara districts	Suaahara monitoring reports	Review reports	Annually	Annual reports	

** Number of FCHVs=11,200 per the Ministry of Health and Population